Health Care Delivery

The Malpractice Claims Experience of Physicians Investigated for Inappropriate Prescribing

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Inappropriate prescribing of controlled substances, primarily opiates and benzodiazepines, is the most common complaint brought before the Oregon Board of Medical Examiners. We describe the malpractice claims experience of 120 physicians previously investigated by the Oregon board for inappropriate prescribing. These physicians were matched with a comparison group by age, specialty, and practice location. We found that a mean of one malpractice claim had been filed against each physician in our study, with the specialties of obstetrics and gynecology, neurosurgery, and orthopedics having the most claims. A significantly higher mean number of malpractice claims had been filed against 31 physicians disciplined by the board. Our study suggests a role for state regulatory boards in the malpractice area. We propose that such bodies do practice reviews based on the convergence of two events, a disciplinary action such as those described in this article and the filing of more than one malpractice claim against a physician. Further research is needed on inappropriate prescribing by physicians and its possible association with malpractice.

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Of the forces reshaping contemporary medicine, certainly none are more powerful than the current malpractice "crisis." From several state legislatures to the Congress of the United States, issues surrounding escalating malpractice premiums are hotly debated. Whether the primary causes of escalating premiums are a lawsuit-conscious public fanned by an oversupply of trial lawyers or an avaricious insurance industry (or both) or by more incompetent physicians than physicians' groups care to admit, premiums continue to rise at alarming rates.[1]

It is important that physicians participate in all aspects of the debate and especially in those concerning physician competence. Physician-dominated regulatory boards are under increasing pressure to monitor more vigorously the clinical practice of physicians under their purview. These pressures are being felt in all sectors of medicine, from local hospital committees to agencies with statewide responsibilities such as boards of medical examiners. The Oregon Board of Medical Examiners (BME) is one of the more active state regulatory boards, recently ranked sixth by the Federation of State Medical Boards in the number of disciplinary actions taken by state boards per 1,000 physicians.[2] Until recently the Oregon board did little about the malpractice problem. Most of its monitoring efforts had dealt with recognizing and rehabilitating impaired physicians[3,4] and creating a program for physicians who prescribe controlled substances inappropriately.[5] Since 1978, insurance companies underwriting liability insurance in Oregon have been required to notify the Oregon BME of malpractice claims filed against Oregon physicians. In 1986 the BME hired a staff physician to examine all claims reviewed to date. Based on the initial review, physicians with four or more claims (n=100) were investigated in greater detail. Of this group, ten were felt to have practice problems that might have contributed to their malpractice claims.[6] Each of the ten physicians was interviewed, and each agreed to modify some of his or her practice. As a result of this initial project, the Oregon BME now does practice reviews on all physicians with three malpractice claims.

No clear data exist on the link, if any, between incompetent care, physician impairment, and malpractice claims. The American College of Surgeons asserts that incompetent care represents substantially less than 25% of malpractice cases.[7] Although it may be tempting to infer a relation between incompetence and malpractice claims,[8] data are lacking.

Our study grew out of a larger one[5] designed to examine characteristics of a group of physicians referred to the Oregon BME from 1981 through 1986 for possibly inappropriate prescribing. Inappropriate prescription writing was the most frequent complaint investigated by the BME, accounting for 51% of the 300 complaints investigated. The study focused on the overprescribing of scheduled drugs, mainly opiates and to a lesser degree benzodiazepines. In the present study, we investigated the relationship between inappropriate prescribing and malpractice claims. Although the literature is tentative, there seems to be an association between inappropriate prescribing, age, practice setting, and

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keeping current in medicine.[9-11] These findings point to the need for the investigation of a possible link between physicians who prescribe inappropriately and those who experience malpractice actions.

Methods

From 1981 through 1986 the board investigated 130 physicians for complaints of inappropriate prescription writing. In a section of the Oregon statutes setting out the grounds for suspending, revoking, or refusing to grant a medical license, inappropriate prescribing is defined as "Prescribing controlled substances without a legitimate medical purpose and without following accepted procedures for examination of patients and record keeping."[12] This definition covers three important areas: a legitimate purpose for prescribing, examination of the patient, and record keeping and is used by both the investigative committee and the full board to judge allegations brought against physicians.

We attempted to match each physician in this group with a noninvestigated physician. Physicians were matched for specialty, degree (MD or DO), sex, Oregon county of practice, and year of medical school graduation. An exact match was required for specialty, degree, and sex. If the county of practice could not be matched exactly, a physician from a county of similar size and location was chosen. The year of medical school graduation was matched within three years. A sample of 120 pairs of physicians was generated.

Demographic information was collected for the comparison sample from the computerized data base maintained by the Oregon BME. Malpractice claims records filed with the board were reviewed for each physician in the study. As noted, since 1978 Oregon law has required insurance carriers writing insurance in Oregon to report to the BME any malpractice claims filed against an insured physician. Claims against physicians insured by non-Oregon companies would not appear in our sample. We assumed that underreporting in the sample would apply equally to both study and comparison groups.

Results

The 120 matched pairs of physicians produced a sample in which the mean age was 53, a mean of 26 years had passed since medical school graduation, and a mean of 22 years since Oregon licensure. Table 1 presents a breakdown of the physicians' medical specialties and the percentage of each practicing in Oregon. Of the study group, 64% were involved in primary care specialties of family practice (33%), general practice (18%), and internal medicine (13%), but only 33% of physicians in practice in Oregon are in primary care.

Table 2 shows the malpractice claims data for both study-group and comparison-group physicians accused of inappropriate prescribing. Of the study-group physicians, 53% had at least one previous malpractice claim. Of comparison physicians, 44% had previous malpractice claims. These differences were not significant (paired t test, $t = 1.32$, $df = 119$, $P = .19$).

Table 3 shows the combined malpractice claims data for both the study and comparison groups presented by medical specialty and by number of claims and mean number of claims per practice category. The most frequently sued physicians are those practicing obstetrics and gynecology, followed closely by neurosurgeons and orthopedists, and then by general surgeons and family practitioners.

TABLE 1.—*Specialties of the Oregon Board of Medical Examiners Sample (n=120) and Comparison Sample (n=120)*

Specialty	Physicians in Each Sample, No.	Physicians in Each Sample, %	% of Oregon Physicians
Family practice	40	33	13
General practice	21	18	5
Internal medicine	15	13	15
Orthopedic surgery	9	8	5
Psychiatry	6	5	5
General surgery	4	3	6
Gastroenterology	3	2	0.9
Neurology	3	2	2
Neurologic surgery	3	2	1
Obstetrics and gynecology	3	2	5
Otolaryngology	3	2	2
Cardiology	2	2	1
Pediatrics	2	2	6
Anesthesiology	1	1	5
Endocrinology	1	1	0.3
Physical medicine and rehabilitation	1	1	0.5
Emergency medicine	1	1	4
Rheumatology	1	1	0.4
Urology	1	1	2

TABLE 2.—*Number of Malpractice Claims*

Number of Previous Claims	Oregon Board of Medical Examiners Group (n=120) No.	Oregon Board of Medical Examiners Group (n=120) (%)*	Comparison Group (n=120) No.	Comparison Group (n=120) (%)*
0	57	(48)	67	(56)
1	33	(28)	32	(27)
2	18	(15)	10	(8)
3	5	(4)	9	(8)
4	4	(3)	2	(2)
5	3	(3)	0	
Mean	1.0		0.7	
Standard deviation	1.4		1.0	

*Percentages total more than 100% because of the rounding off of numbers.

TABLE 3.—*Malpractice Claims by Specialty*

	No. of Physicians (n=240)	No. of Claims (n=207)	Mean No. of Claims
Family practice	80	78	0.98
General practice	42	28	0.67
Internal medicine	30	13	0.43
Orthopedic surgery	18	35	1.94
Psychiatry	12	0	0.00
General surgery	8	11	1.38
Gastroenterology	6	4	0.67
Neurology	6	2	0.33
Neurologic surgery	6	12	2.00
Obstetrics and gynecology	6	13	2.17
Otolaryngology	6	5	0.83
Cardiology	4	2	0.50
Pediatrics	4	2	0.50
Anesthesiology	2	0	0.00
Endocrinology	2	0	0.00
Physical medicine and rehabilitation	2	0	0.00
Emergency medicine	2	0	0.00
Rheumatology	2	2	1.00
Urology	2	0	0.00

Of the 120 physicians investigated for inappropriate prescribing, 71 (59%) had their cases closed at the investigative committee level. Of these, 24 (34%) were sent a letter of concern regarding their practices, but their cases were not deemed serious enough for future consideration by the full board. The other 49 cases (41%) were sent on to the full board. We found no significant differences in the number of malpractice claims of the study and comparison groups when we compared physicians whose cases were closed at the investigative committee level with those sent on to the full board (2-factor analysis of variance).

Of the 49 cases sent to the full board, 31 had their prescribing privileges limited. These physicians agreed to give up their privilege to prescribe schedule II, III, and IV drugs. When we compared the malpractice claims experience of this group of 31 disciplined physicians with their matched comparisons, we did find a significant difference in the number of claims. The 31 physicians in the study group had a mean of 1.2 malpractice claims compared with 0.6 for their matched physicians (paired t test, $t = 2.21$, $df = 30$, $P = .035$).

Discussion

Our study is a preliminary investigation of the malpractice claims experience of a group of Oregon physicians who were brought to the attention of the Oregon BME for suspected inappropriate prescribing of controlled substances and a comparison of this group with a matched comparison group.

With 53% of the study group and 44% of the comparison group having at least one malpractice claim, we concluded that all physicians are vulnerable to suit. Because only Oregon underwriters are required by law to report malpractice claims to the BME, malpractice claims for both the study and comparison groups are underreported. For example, most psychiatrists receive their malpractice coverage through nationally sponsored policies. Although psychiatrists are not frequently sued,[13] we did have 12 psychiatrists in the study with no malpractice claims reported to the Oregon BME.

The malpractice findings also mirror national trends in those branches of medicine most vulnerable to lawsuit. Although the study group is heavily dominated by primary care physicians, those practicing obstetrics and gynecology, neurosurgery, and orthopedics have the highest number of malpractice claims filed against them.

We did find a significant difference in the mean number of malpractice claims filed against the 31 physicians disciplined for inappropriate prescribing (1.2 claims per physician) and their matched physician controls (0.6 per physician). These findings are consistent with a view of inappropriate prescribers as a potential group of high-risk physicians[14] worthy of more intensive study and possible remediation.

Our data do not help determine the percentage of malpractice claims that are actually cases of malpractice, representations of incompetence, or both. They do suggest, however, that the Oregon board's policy of reviewing a physician's practice after a certain number of malpractice claims could be beneficial and that there is value in doing more comprehensive practice reviews when two events converge, a disciplinary action for inappropriate prescribing coupled with the existence of malpractice claims. Such practice review may allow for an earlier identification of physicians at risk for practice problems and may improve the chances of discovering problems with physicians practicing in specialties at a lower risk for malpractice claims. Simply using the number of claims filed against a physician without a disciplinary action discriminates against the high-risk specialists who are more likely to experience malpractice suits.

Our study results point to a role for a regulatory body such as the Oregon BME in the malpractice arena. Clearly more research is needed in this area. Will our findings hold up after further examination or with more complete malpractice data? Do the same trends exist in relation to impaired physicians? We are currently investigating these questions and urge others to do the same, as these are areas of major importance. With medicine's house more in order, we will be freer to help bring about other needed reforms in the malpractice area.

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